BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

ROBERT D. HULL	)	
Claimant	)	
	)	
VS.	)	
	)	
SPIRIT AEROSYSTEMS, INC.	)	
Respondent	)	Docket No. **1,037,725**
	)	
AND	)	
	)	
AMERICAN HOME ASSURANCE CO.	)	
Insurance Carrier	)	

ORDER

Respondent and its insurance carrier request review of the August 18, 2009 Award by Administrative Law Judge Nelsonna Potts Barnes. The Board heard oral argument on November 20, 2009.

APPEARANCES

Phillip B. Slape of Wichita, Kansas, appeared for the claimant. Eric K. Kuhn of Wichita, Kansas, appeared for respondent and its insurance carrier.

RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award.

ISSUES

On September 6, 2007, claimant tore a skin graft on his right ankle at work when he struck his ankle on the crank of a bicycle pedal. Weeks later claimant's ankle became infected and, consequently, claimant was hospitalized. The Administrative Law Judge (ALJ) found claimant sustained a 25 percent permanent partial disability to the right leg as a result of the September 2007 accident. Moreover, the ALJ ordered respondent "to pay the itemized, outstanding medical bills and further to pay future medical expenses upon proper application."[1]

[1] ALJ Award (Aug. 18, 2009) at 4.

First, respondent contends it is not responsible for the infection in claimant's ankle or any permanent disability that resulted from that infection. Accordingly, respondent maintains that claimant should receive no permanent disability benefits in this claim as he failed to prove what impairment arose solely from the initial ankle abrasion. In the alternative, respondent argues that the Board should adopt Dr. Pat Do's opinion that claimant sustained a 12 percent impairment to the right lower extremity. Next, respondent contends that it should not be held responsible for the medical charges claimant incurred for treating his infection as respondent had no knowledge the bills were being incurred, did not authorize the medical treatment, and none of the bills were reduced pursuant to the Director's fee schedule. Indeed, respondent argues "all of the charges submitted by the providers to claimant . . . are void and uncollectable because they are in excess of the proper amounts contained in the Fee Schedule."[2]

Claimant, on the other hand, argues the Board should award claimant permanent disability benefits for either a 15 percent whole person impairment or a 38 percent impairment to the right lower extremity and order respondent to pay his medical expenses. Claimant maintains the opinions from Dr. Robert Eyster are not admissible because a letter drafted by respondent's counsel setting forth the doctor's medical opinion was not provided to claimant in a timely manner and, therefore, allegedly violates K.S.A. 44-515. Next, claimant argues the medical treatment he initially received beginning November 3, 2007, was pursuant to a medical emergency and that the ALJ then authorized Dr. Bruce Ferris to treat claimant. Moreover, claimant asserts that each representative of every health care provider who treated claimant testified that their billings were in proper form for payment under the Workers Compensation Act (Act) and that respondent has failed to notify any provider that its billing was not in proper form.

The issues before the Board on this appeal are:

1. Was the infection in claimant's right lower extremity a natural consequence of his September 6, 2007 accident?

2. What impairment, if any, did claimant experience as a result of his September 6, 2007 accident?

3. Should respondent be ordered to pay the medical bills incurred by claimant for treatment of his right ankle injury and the resulting infection?

4. Should billings from the Plastic Surgery Center, Wichita Specialty Hospital, and VCMC be excluded from the record because those billings were not first adjusted to the amounts allowed by the Division of Workers Compensation Fee Schedule?

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[2] Respondent's Brief at 8 (filed Oct. 2, 2009).

5. Are Dr. Robert Eyster's opinions admissible?

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After reviewing the entire record and considering the parties' arguments, the Board finds and concludes:

Respondent employed claimant as an inspector. He was provided with a three-wheeled bicycle, which he had used years before, to get around in respondent's manufacturing plant. Because of paralysis and footdrop in the right foot, claimant's right foot would slide on the pedal until his ankle would bang on the pedal's crank. Shortly before September 6, 2007, respondent took away the golf cart that claimant was using and told him to use the bicycle.

Claimant is a 61-year-old diabetic. He also has a loss of sensation in his right leg due to an earlier back surgery in which a nerve was severed. Approximately 10 years ago claimant developed an infection in his right ankle and underwent a skin graft in that area. Claimant suspects that the infection was related to banging and injuring his ankle on the bicycle he rode at work.

There is no dispute that on September 6, 2007[3], claimant struck his right ankle on the crank of the bicycle pedal and tore his skin graft. Claimant was alerted to the injury when he noticed blood on his sock. He promptly reported the incident to his supervisor and was sent to respondent's medical department, where he began receiving daily changes of dressings. When the medical department discontinued treatment, which was around October 15, 2007, claimant's right ankle injury had not entirely healed as there remained a scab. On October 31, 2007, claimant was terminated.

On November 3, 2007, claimant developed swelling and excruciating pain from the right knee down and was rushed to the hospital and admitted to the intensive care unit for treatment. In the early morning hours of November 4, the chaplain's office at the Via Christi Medical Center (VCMC) telephoned claimant's wife and requested her presence as claimant was near death. Claimant had developed a right leg infection and cellulitis that required incision and drainage. He stayed at VCMC from November 3 through November 15, 2007, when he was transferred to Wichita Specialty Hospital (WSH) for additional weeks of IV antibiotics. Claimant received care at WSH from November 15 through December 14, 2007. On December 24, 2007, claimant had a flare-up of pain and returned to VCMC, where he was again admitted.

[3] Claimant testified the injury to his right ankle occurred on either September 6 or 11, 2007. In either event, there was only one accident that comprises this claim.

Dr. Bruce Ferris, a plastic surgeon, treated claimant from January 2008 through July 2008. The doctor grafted skin on claimant's right leg from just below the knee to the ankle. By Order dated April 8, 2008, the ALJ authorized Dr. Ferris to treat claimant.

Claimant has incurred substantial medical bills for the treatment of his right ankle and the ensuing infection. For example, claimant incurred medical expenses for a wound vacuum machine, infectious disease specialist Dr. Keck Hartman, home health services companies (Home Medical Service and Interim Health Care), Dr. Ferris, VCMC, WSH, and Dr. Truong Thanh (at WSH). And those expenses total more than $100,000.

Three doctors testified in this claim including Dr. Robert L. Eyster, who oversaw claimant's treatment during his November 2007 stay at VCMC; Dr. Michael H. Munhall, who was claimant's medical expert; and Dr. Pat D. Do, who examined claimant once at the ALJ's request and once at respondent's request.

Dr. Munhall is board-certified in physical medicine and rehabilitation. His experience in soft tissue infections comes from a one-year stint in internal medicine, working in a burn ward during his residency in physical medicine and rehabilitation, and completing an amputee rotation at a Veterans Administration medical center. Accordingly, the doctor feels he has significant experience dealing with infections requiring amputation. Dr. Munhall, who examined claimant in late July 2008 opined that claimant's right ankle abrasion from the bicycle at work ultimately led to infection. The doctor testified, in part:

> Q. (Mr. Slape) Okay. And can you explain what problems he had as a result of the abrasion and its sequelae of infection and sepsis?
>
> A. (Dr. Munhall) Certainly. The right medial ankle abrasion led to soft tissue infection we call cellulitis. That led to a deeper infection that went into the blood system causing sepsis which required IV medication antibiotics. The sepsis caused acute renal failure. He was admitted to the intensive care unit. The changes in his metabolic parameters included rising creatinine, intrarespiratory acidosis. IV medication including IV fluids led to congestive heart failure which led to pulmonary infiltration and pulmonary edema. Those changes led to changes in his heart rhythm, he went into atrial fibrillation with a fast ventricular response. It required cardiology evaluation, consultation, medications and conversion back to normal sinus rhythm. Medications on admission included IV Dilaudid and then morphine. The morphine caused respiratory insufficiency, actually caused a respiratory arrest. He was coded, required ventilation support and then from there he was transferred to the coronary care unit to work up any cardiac abnormalities, any cardiac decline from that respiratory arrest. Cellulitis advanced was not responsive to IV medication and required ultimately medial, lateral fasciotomies, fasciectomies to the right lower extremity.[4]

[4] Munhall Depo. at 10-11.

Dr. Munhall reviewed claimant's medical records and concluded that claimant's medical treatment was reasonable and necessary to cure and relieve the effects of both the initial right ankle injury and the infection, which the doctor felt was a direct and natural consequence of that injury.[5] Dr. Munhall believes claimant's underlying diabetes (metabolic problem) and footdrop (circulation loss) predisposed claimant to infections. Further, the doctor rated claimant as having a 15 percent whole person impairment or 37 percent impairment to the lower extremity as measured by the AMA *Guides.*[6]

Initially, it must be noted that respondent objected to Dr. Munhall's testimony on the basis of lack of foundation and lack of expertise. The Board disagrees and overrules respondent's objection. First, Dr. Munhall's medical training and experience includes working with both diabetic patients and those having infections. Moreover, K.S.A. 44-515(e) provides that such opinion shall be considered. That statute provides:

> **Any health care provider's opinion**, whether the provider is a treating health care provider or is an examining health care provider, regarding a claimant's need for medical treatment, inability to work, prognosis, diagnosis and disability rating **shall be considered and given appropriate weight** by the trier of fact together with consideration of all other evidence. (Emphasis added.)

Dr. Do, a board certified orthopedic surgeon, examined claimant on two occasions; once in February 2008 (at the ALJ's request to determine causation) and once in September 2008 (at the respondent's request to assess functional impairment). Following the February 2008 examination, Dr. Do reported to Judge Barnes that it was his medical opinion "that within a reasonable degree of medical probability the claimant's current conditions [sic] is partially due to the ankle abrasion as well as partially due to the compromised skin and foot function that has been present for 10 years."[7]

Nonetheless, Dr. Do initially testified at his deposition that it was equally likely that claimant's infection resulted from one of three potential causes; namely, the abrasion from the bicycle, claimant's picking skin from around the wound, or the infection merely occurred due to claimant's diabetic condition.[8] But on cross-examination the doctor reiterated that claimant's hospitalization and treatment were partially related to the cut or abrasion sustained at work. The doctor testified, in part:

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[5] *Ibid.* at 13.

[6] American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

[7] Do Depo., Ex. 2 at 6.

[8] *Ibid.* at 6.

> Q. (Mr. Slape) Doctor, when you saw this patient the first time and issued your report to the court, you stated that the hospitalization and the treatment that Mr. Hull received was at least partially related to the cut, abrasion to his ankle; is that true?
>
> A. (Dr. Do) If it is in my report, yes. But what you are saying, it would be true today.[9]

Nevertheless, Dr. Do then testified the abrasion from the bicycle pedal was only one of three potential causes of claimant's need for medical treatment and that he could not state that one of those potential causes was more likely than the other two.[10]

Following the September 2008 examination, Dr. Do concluded claimant sustained a 5 percent whole person impairment or a 12 percent impairment to the lower extremity as measured by the AMA *Guides.* But the doctor testified claimant actually fell in a higher impairment classification that comprised a 10 to 24 percent whole person impairment.[11] The doctor explained the 5 percent whole person impairment rating took into consideration claimant's preexisting neuropathy, footdrop and ankylosed ankle.[12]

Dr. Eyster, who is a board-certified orthopedic surgeon, oversaw claimant's treatment during his November 2007 stay at VCMC and surgically removed the dead tissue from claimant's wound. In late February 2009, Dr. Eyster met with respondent's attorney, who afterwards prepared a letter dated February 27, 2009, summarizing the doctor's opinions. The doctor acknowledged the letter set forth his opinions. Claimant's attorney did not receive a copy of the letter until Dr. Eyster's June 2009 deposition when, citing K.S.A. 44-515, claimant objected to both the letter and the doctor's testimony.

Dr. Eyster testified, over claimant's objection, that it was his experience that 70 percent of the time cellulitis begins without there being any preexisting infection or scab and that for whatever reason the bacteria (usually strep or staph) deposits in the subcutaneous tissue and begins to grow. Dr. Eyster opined that it was far and away most likely that claimant's cellulitis merely recurred where it had previously existed years ago rather than it resulting from a new injury.[13]

> Q. (Mr. Kuhn) So, doctor, your opinion in this case, just so I can summarize, and correct me if I am putting words in your mouth, nobody knows for sure what the

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[9] *Ibid*. at 9.

[10] *Ibid*. at 24 & 27.

[11] *Ibid*. at 15-16.

[12] *Ibid*., Ex. 3 at 7.

[13] Eyster Depo. at 9-10.

> cause of this cellulitis condition is. But based upon all the things that we discussed, the records we reviewed, this gentleman's testimony, the more likely cause is just the mere fact that he is a diabetic and had a pre-existing condition in the same area; is that correct?
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> A. (Dr. Eyster) That would be the most likely scenario as I have testified to.[14]

But the doctor acknowledged that because of claimant's previous infection and diabetic condition claimant has diminished blood supply and, therefore, he had a greater likelihood of developing an infection from any cut or abrasion in the lower extremities. Moreover, when Dr. Eyster sees patients with both cellulitis and diabetes he asks them if they have any cuts or abrasions on their lower extremities.

In concluding that claimant's infection was not related to the right ankle injury at work, Dr. Eyster considered as important the timing of claimant's infection and that claimant's abrasion was healing without either streaking or signs of actual laceration.

As indicated above, claimant objected to Dr. Eyster's opinions under K.S.A. 44-515 as respondent allegedly failed to provide in a timely manner claimant's attorney with a copy of the letter that contained the doctor's opinions. K.S.A. 44-515(a) provides, in part:

> After an employee sustains an injury, the employee shall, upon request of the employer, submit to an examination at any reasonable time and place by any one or more reputable health care providers, selected by the employer, and shall so submit to an examination thereafter at intervals during the pendency of such employee's claim for compensation, upon the request of the employer, but the employee shall not be required to submit to an examination oftener than twice in any one month, unless required to do so in accordance with such orders as may be made by the director. **Any employee so submitting to an examination or such employee's authorized representative shall upon request be entitled to receive and shall have delivered to such employee a copy of the health care provider's report of such examination within 15 days after such examination, which report shall be identical to the report submitted to the employer.** (Emphasis added.)

The Board finds and concludes claimant's objection to Dr. Eyster's testimony and opinions must be overruled. K.S.A. 44-515(a) is not applicable as the letter in question was not generated as the result of a medical examination requested by respondent. Consequently, Dr. Eyster's opinions are part of the record.

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[14] *Ibid.* at 13.

Nature and Extent of Impairment

Considering the entire record, the Board finds it is more probably true than not that claimant's infection developed as a natural consequence of the injury he sustained at work to his right ankle. Due to claimant's diabetes and footdrop claimant was predisposed to developing an infection. Since the bout in the 1980s, claimant had gone years without redeveloping an infection. It is more than mere coincidence that claimant developed an infection in his right lower extremity shortly after lacerating his skin graft. In reaching this determination, the Board has also carefully considered the fact that Dr. Do initially related claimant's hospitalization and treatment to the injury at work but changed that opinion after being hired by respondent to provide a functional impairment opinion.

The Board affirms the ALJ's determination that claimant sustained a 25 percent impairment to the right leg. Nevertheless, claimant's permanent disability benefits should be computed under the schedule of K.S.A. 44-510d as an injury to the lower leg as the evidence fails to establish an injury to the knee or the upper leg.

Medical Bills

Claimant has incurred thousands of dollars in medical expenses in treating the infection that developed following his accident. As indicated above, respondent contends it is not responsible for those medical charges as it had no knowledge the bills were being incurred, did not authorize the medical treatment, and none of the bills were reduced pursuant to the Division of Workers Compensation (Division) schedule of medical fees.

Paulette LeValley, business manager for the Plastic Surgery Center, introduced billings totaling $1,747 (on forms CMS-1500) for services rendered claimant by her employer. Ms. LeValley testified her company's billings are submitted to the appropriate insurance carrier either electronically or on an HCFA 1500 form. Moreover, she indicated her company does not adjust its billings according to the Workers Compensation Fee Schedule but, instead, when "[w]ork comp comes back, tells us what the fee schedule is, we adjust the bills accordingly because we are providers, and we don't submit them [the billings] with the work comp fee schedule ever."[15] Respondent objected to the billings for several reasons; namely, that they were not pursuant to the Division's fee schedule in form or amount, the charges were not shown to be reasonable, necessary, or related to this claim.[16]

Ms. LeValley indicated claimant's bills were submitted to his health insurance carrier rather than to a workers compensation insurance carrier and that they have been satisfied.

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[15] LeValley Depo. at 6.

[16] *Ibid.* at 5.

Myra Dick, business office manager for WSH, introduced billings totaling $52,280.58 for charges incurred by claimant during his stay in November and December 2007. The billings included a form UB-04, which Ms. Dick testified was the form her company utilized to submit charges to insurance carriers, with no distinction being made between a workers compensation insurance carrier or a health insurance carrier. Respondent objected to the billing on the basis of relevancy and that it was "not pursuant to the Kansas statutes pertaining to the fee schedule in either form or amount."[17]

Ms. Dick indicated the charges were submitted to claimant's health insurance carrier and that claimant's account has been paid. Moreover, she indicated she does not know if her company's charges comply with the Division's fee schedule.

Robin Knotts, who is the legal coordinator of patient financial services for VCMC, introduced two UB-04 forms showing the charges claimant incurred during his two stays from November 3 through 15, 2007, and from December 24, 2007, through January 2, 2008. And attached to both UB-04 forms are itemized billings. Ms. Knotts explained that it is customary for VCMC to send its UB-04 to the appropriate insurance carrier, who either pays the bill, denies the charges, or requests additional information. Ms. Knotts acknowledged that the billings are not reduced to that allowed by the Division's fee schedule until payment is received and the appropriate portion of the bill is written off.

According to Ms. Knotts, claimant's bill is unpaid. The first UB-04 shows charges of $95,620.02 and the second shows charges of $20,672.30.

Respondent objected to VCMC's billings on the basis there was "no representation that the bills have been submitted pursuant to the fee schedule under the Kansas Workers' Compensation Act."[18]

In addition to the specific medical billings discussed above, the parties stipulated that other medical bills were in proper form and to be considered as part of the record subject, however, to respondent's objections the statements were "not submitted pursuant to the fee schedule, are not related, necessary or reasonable and they are unauthorized."[19]

Erica Fichter, director of operations of medical bill review for Broadspire[20], testified that she oversees the medical bill review functions for her company's clients in the

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[17] Dick Depo. at 8.

[18] Knotts Depo. at 10.

[19] Stipulation of Medical Bills filed on April 16, 2009.

[20] In respondent's application for review, Broadspire Services is shown as respondent's insurance carrier.

company's Plantation and Atlanta office. Ms. Fichter is familiar with medical billings from Kansas in general and with respondent in particular. Indeed, respondent's counsel shows Broadspire as the insurance entity in the application for review filed in this claim.

Ms. Fichter testified that the medical billings Broadspire receives on behalf of the company's clients usually have not been reduced pursuant to the Division's fee schedule. Consequently, upon receipt of a billing, Broadspire places the medical bill in its bill review system that adjusts the billing to comply with the Division's fee schedule. Broadspire then issues the medical provider a check with an explanation of its adjustments. According to Ms. Fichter, facilities generally use a UB-04 form for their billings but the professional health care providers typically use the 1500 form. And should a billing be submitted on a form that does not comply with law, Broadspire returns that billing to the provider.

The Board concludes respondent's objection to the bills on the basis that they do not comply with the Division's fee schedule should be overruled. Although it is true the liability of an employer or its insurance carrier is limited by the fee schedule, the bills may be introduced into the record as they have probative value as to the services provided. In this context, the Board is unaware of any statute in the Act or any appellate decision that would require the bills to be excluded from the record.

The Act provides a specific procedure when an employer's insurance carrier or a self-insured employer disputes all or a portion of a medical bill. See K.S.A. 44-510j, which provides for both formal and informal hearings, utilization review, and peer review. The Division of Workers Compensation has been conducting utilization review and peer review proceedings for several years. Moreover, the statute provides its own appeal procedure and appellate standard of review.

The Board finds and concludes respondent is responsible for all the medical expenses claimant incurred for treatment of his right ankle and the resulting infection subject, of course, to the Division's fee schedule. The Board finds that claimant needed emergency medical treatment and, therefore, he was not required to first seek authorization from respondent or its insurance carrier.[21]

In summary, claimant is entitled to receive permanent partial disability benefits under K.S.A. 44-510d for a 25 percent impairment to his right lower leg, payment of medical expenses he incurred for treatment of his right ankle injury and resulting infection subject to the fee schedule, and future medical care and treatment upon proper application to the Director.

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[21] *See* 8 *Larson's Workers' Compensation Law* §94.02[6] (2009).

AWARD

WHEREFORE, it is the decision of the Board that the Award of Administrative Law Judge Nelsonna Potts Barnes dated August 18, 2009, is modified to reflect claimant is entitled to receive permanent partial disability benefits under K.S.A. 44-510d for a 25 percent impairment to his right lower leg.

Claimant is entitled to 40 weeks of temporary total disability compensation at the rate of $510 per week in the amount of $20,400 followed by 37.50 weeks of permanent partial disability compensation, at the rate of $510 per week, in the amount of $19,125 for a 25 percent loss of use of the lower leg, making a total award of $39,525, which is due, owing and ordered paid in one lump sum less amounts previously paid.

The Board further finds that claimant is entitled to payment of medical expenses he incurred for treatment of his right ankle injury and resulting infection as well as future medical care and treatment upon proper application to the Director.

IT IS SO ORDERED.

Dated this _____ day of April 2010.

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BOARD MEMBER

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BOARD MEMBER

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BOARD MEMBER

c: Phillip B. Slape, Attorney for Claimant
Eric K. Kuhn, Attorney for Respondent and its Insurance Carrier
Nelsonna Potts Barnes, Administrative Law Judge